NON-MDL CENSUS FORM

Background Information:

1. **Claimant's name: _____**
   If minor, name and address of parents: _____

Parent address:	Child address (if different):

2. **Date of Birth: _____** **Date of Death (if applicable): _____**
3. **State of Residence: _____** **State of Death (if applicable): _____**
4. **Gestational age of infant at birth: _____**
5. **Weight of infant at birth: _____**

Diagnosis, Treatment

1. **Was infant diagnosed with NEC?**
   Circle one: Yes No

2. **Please identify the date and approximate time of the infant's NEC diagnosis in the box below and produce with this document the medical records showing the timing of the infant's NEC diagnosis.**

3. **Name and address of facility where born:**

4. **Name and address of facility where diagnosed with NEC, if different:**

5. **Type(s) of Injuries:**

6. **Type(s) of treatment:** **Dates (Start, End):**

7. **Did the infant undergo any surgery(ies) to treat his/her NEC?**
   Circle one: Yes No
8. **Name and address of all healthcare providers who diagnosed and treated NEC:**

9. **Describe any ongoing medical problems or treatments related to NEC and identify any healthcare providers providing treatment for such medical problems.**

Medical Problems
Treating Providers

10. **Please indicate whether you are aware of the Infant having been diagnosed with any of the following conditions or procedures or receiving any of the following medications during the Infant's hospitalization for his/her birth or in the NICU (if transferred), whichever is later.**

Condition, Procedure, or Medication:	Yes	No	Don't Know/ Recall	Healthcare Provider
Prematurity	☐	☐	☐	
Low birth weight	☐	☐	☐	
Sepsis	☐	☐	☐	
Congenital heart disease	☐	☐	☐	
Assisted ventilation	☐	☐	☐	
Patent ductus arteriosus	☐	☐	☐	
Anemia	☐	☐	☐	
Administration of Indomethacin	☐	☐	☐	
Administration of glucocorticoids	☐	☐	☐	
Gastroschisis	☐	☐	☐	
Red blood cell transfusion	☐	☐	☐	
Hypoxia	☐	☐	☐	
Hypotension	☐	☐	☐	

Hypoalbuminemia	☐	☐	☐	
Family history of necrotizing enterocolitis	☐	☐	☐	

Please produce the medical records of the Healthcare Providers and institutions identified above and any other of the Infant's medical records collected by or provided to your attorneys that are in counsel's possession as of the date this Non-MDL Census Form is executed.

11. Please indicate whether Mother's medical history includes any of the following conditions, procedures, or medications during her pregnancy with the Infant.

Condition, Procedure, or Medication:	**Yes**	**No**	**I don't recall/ know**	**Date(s) of Condition, Procedure, or Medication**	**Treating Physician(s)**
Chorioamnionitis	☐	☐	☐		
Pre-eclampsia	☐	☐	☐		
In utero growth restriction	☐	☐	☐		
Placental abruption	☐	☐	☐		
Prenatal antibiotics	☐	☐	☐		
Prenatal corticosteroids	☐	☐	☐		
Intrahepatic cholestasis during pregnancy	☐	☐	☐		
Premature rupture of membranes (water breaking early)	☐	☐	☐		
Smoking	☐	☐	☐		
Cocaine use	☐	☐	☐		
Methamphetamine use	☐	☐	☐		
Amphetamine use	☐	☐	☐		
Alcohol use	☐	☐	☐		
HIV	☐	☐	☐		

Please produce the medical records of the Healthcare Providers and institutions identified above that are in counsel's possession as of the date this Non-MDL Census Form is executed.

Feeding Information

A. Was cow-milk based formula given to the infant:

Circle one: Yes No I don't know

B. Was cow-milk based fortifier given to the infant:

Circle one: Yes No I don't know

C. Name of facility where cow-milk based formula or fortifier was given the infant:

D. **Please list all brands and specific names of formula/fortifier administered to the infant, if known at this time:**

E. **Was Mother's Own Milk (expressed or via breastfeeding) given to the infant before he/she was diagnosed with NEC?**

Circle one: Yes No

F. **Was Mother's Own Milk (expressed or via breastfeeding) available to the infant at the time he/she was fed formula?**

Circle one: Yes No I don't know

G. **Was infant given donor breast milk?**

Circle one: Yes No I don't know

H. **Did the infant's NICU have donor breast milk available for the infant before his/her NEC diagnosis?**

Circle one: Yes No I don't know

I. **If you answered "I don't know" in response to question C above, was donor breast milk ever discussed or mentioned to you at the infant's NICU?**

Circle one: Yes No

If Yes, please explain:

J. **Was there enough human milk—either Mother's Own Milk or donor milk—available to the infant to avoid the use of any cow-milk based formula while the infant was in the NICU?**

Circle one: Yes No I don't know

K. **Please produce with this document the "Intake and Output" medical records for the infant for the period between birth and the date and time of NEC diagnosis.**

L. **If you do not have the "Intake and Output" medical records, please produce with this document all medical records in your possession showing the type and volume of mother's own breast milk, donor breast milk, formula, and fortifier fed to the infant from birth through the date and approximate time of NEC diagnosis. In addition to producing the records, you may also describe your understanding of the composition of such feedings in the space provided below.**

M. **Your signature below constitutes your affirmation that the statements made in this document are true and correct to the best of your knowledge, information, and belief.**

_____	_____	_____
Date	Signature of Claimant	Printed Name of Signing Claimant